(b) *Capital cost reimbursement waivers.* The Department may grant waivers of subsection (a) to permit capital cost reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department will publish a statement of policy under §9.12 (relating to statements of policy) specifying the criteria that it will apply to evaluate and approve applications for capital cost reimbursement waivers.

§1187.113a. Nursing facility replacement beds -- statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for replacement beds constructed, licensed or certified after November 29, 1997.

(b) *Purpose.*

(1) Department regulations relating to capital component payments for nursing facilities enrolled and participating in the Commonwealth's Medical Assistance (MA) Program state that capital component payments for replacement beds are allowed only if the nursing facility was "issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health". See § 1187.113(a)(3) (relating to capital component payment limitations).

(2) Chapter 7 and all other portions of the Health Care Facilities Act (35 P.S. §§ 448.701 -- 448.712) pertaining to Certificates of Need (CON) sunsetted on December 18, 1996. To allow the Department to continue to make capital component payments for replacement beds for which a nursing facility does not have a CON or letter of nonreviewability, the Department will amend its regulations to specify the conditions under which it will recognize beds as replacement beds for purposes of making capital component payments. Pending the promulgation of these regulations, the Department has issued this section to specify instances in which the Department will make capital component payments for replacement beds.

(c) *Requests for approval of replacement beds.* A nursing facility provider that intends to seek capital component payments under § 1187.113(a)(3) for nursing facility beds constructed, licensed or certified after November 29, 1997, shall submit a written request to the Department for approval of the beds as replacement beds.

(1) The facility shall submit an original and two copies of its request prior to beginning construction of the beds. If a facility began construction

of the beds prior to November 29, 1997, the facility shall submit an original and two copies of its request by February 27, 1998, or the date on which the facility requested the Department of Health to issue a license for the beds, whichever date is earlier.

(2) A facility that fails to submit a request under paragraph (1) may not receive capital component payments for the beds.

(d) *Policy regarding approval of replacement beds.*

(1) *Nursing facility beds authorized under a CON dated on or before December 18, 1996.*

(i) The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if the following conditions are met:

(A) The facility has a CON or letter of nonreviewability dated on or before December 18, 1996, authorizing the replacement bed project.

(B) The facility has "substantially implemented" its project, as defined in 28 Pa. Code § 401.2 (relating to definitions).

(C) The beds that are being replaced:

(I) Are currently certified.

(II) Are premoratorium beds.

(III) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(ii) If a facility has a CON dated on or before December 18, 1996 authorizing a replacement bed project, but the facility fails to substantially implement its project as defined in 28 Pa. Code § 401.2, the Department will treat the facility as though it does not have a CON, and consider the facility's request under paragraph (2).

(2) *Nursing facility beds not authorized by a CON dated on or before December 18, 1996.* The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if after applying the guidelines set forth in subsection (e), the Department determines that the following conditions are met:

(i) Construction of the replacement beds is necessary to assure that MA recipients have access to nursing facility services consistent with applicable law. If the Department determines that some, but not all, of the replacement beds are necessary to assure that MA recipients have appropriate access to nursing facility services, the Department may limit its approval to the number of beds it determines are necessary. If the Department limits its approval to some of the beds, the remaining unapproved beds will not qualify for capital component payments.

(ii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be constructed within a one-mile radius of the existing structure in which the beds that are being replaced are situated.

(iii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located a further distance from the existing structure, the replacement beds will be attached or immediately adjacent to the existing structure in which beds that are being replaced are situated if the replacement beds will replace only a portion of the beds in the existing structure.

(iv) The beds that are being replaced:

(A) Are currently certified.

(B) Are premoratorium beds.

(C) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(e) *Guidelines for evaluation of requests to construct replacement beds.* The Department will use the following guidelines, and will consider the following information, as relevant in determining whether to approve replacement beds under subsection (d)(2).

(1) Whether, and to what extent, construction of all the replacement beds is required to ensure the health, safety and welfare of the residents of the facility.

(2) Whether, and to what extent, building code violations or other regulatory violations exist at the facility requiring the construction of all of the replacement beds. If the provider alleges these violations, it shall attach waivers from the relevant regulatory agencies, and explain why the waivers of code violations may not continue indefinitely.

(3) Whether, and to what extent, the facility has considered the development of home and community-based services in lieu of replacing some or all of its beds.

(4) Whether other support services for MA recipients, including home and community-based services, are available in lieu of nursing facility services.

(5) Whether the overall total occupancy and MA occupancy levels of the facility and facilities in the county indicate that there is a need for all or a portion of the replacement beds.

(6) If the provider is proposing to construct a new facility or wing, whether the provider has satisfactorily demonstrated that it would be more costly to renovate the provider's current facility rather than to construct the new facility or wing.

(7) Whether the facility, or section of the facility, which currently contains the beds to be replaced is able to be utilized for another purpose.

(f) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Premoratorium beds - Nursing facility beds that were built under an approved CON dated on or before August 31, 1982, and for which the Department is making a capital component payment under these regulations.

Replacement beds - Nursing facility beds constructed in a new building or structure that take the place of existing beds located in a separate or attached building or structure; or reconstructed or renovated beds within an existing building or structure when the cost of the reconstruction or

renovation equals or exceeds 50% of the total facility's appraised value in effect for the rate period in which the request is made.

§1187.114. Adjustments relating to sanctions and fines.

Nursing facility payments shall be withheld, offset, reduced or recouped as a result of sanctions and fines in accordance with Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

§1187.115. Adjustments relating to errors and corrections of nursing facility payments.

Nursing facility payments shall be withheld, offset, increased, reduced or recouped as a result of errors, fraud and abuse or appeals under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies) and §1187.141 (relating to nursing facility's right to appeal and to a hearing).

§ 1187.116. County nursing facility supplementation payments.

County nursing facility supplementation payments are made according to a formula established by the Department to county nursing facilities, in which Medicaid funded resident days account for at least 80% of the facility's total resident days and the number of certified MA beds is greater than 270 beds. Payment of the county nursing facility supplementation payments is contingent upon the determination by the Department that there are sufficient State and Federal funds appropriated to make these supplementation payments.

SUBCHAPTER I. ENFORCEMENT OF COMPLIANCE FOR NURSING FACILITIES WITH DEFICIENCIES.

§1187.121. Applicability.

(a) This subchapter addresses the application of remedies established by Federal law to be effective July 1, 1995.

(b) The remedies will be applied on the basis of noncompliance found during surveys conducted by the survey agency or audits, reviews or inspections conducted by the Department or the Auditor General's Office.

§1187.122. Requirements.

(a) The Department incorporates by reference 42 CFR 488.400 - 488.456 (published in 59 FR 56243 - 56250 (November 10, 1994)) or, as amended, as the enforcement of compliance regulations for nursing facilities with deficiencies.

(b) Directed in-service training as contained in 42 CFR 488.406 and 488.425 (relating to available remedies; and directed inservice training) or, as amended, may be imposed as a remedy.

SUBCHAPTER J. NURSING FACILITY RIGHT OF APPEAL

§1187.141. Nursing facility's right to appeal and to a hearing.

(a) A nursing facility has a right to appeal and have a hearing if the nursing facility does not agree with the Department's decision regarding:

(1) The peer group prices established annually by the Department for the peer group in which the nursing facility is included. The nursing facility may appeal the peer group prices only as to the issue of whether the peer group prices were calculated in accordance with §1187.96 (relating to price and rate setting computations).

(i) A nursing facility may not challenge the validity or accuracy of any adjustment (except as provided in subsection (a)(10)) or any desk or field audit findings relating to the database or total facility CMIs used by the Department in calculating the peer group prices as a basis for its appeal of the peer group prices.

(ii) If more than one nursing facility in a peer group appeals the peer group prices established by the Department, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(2) The findings issued by the Department in a desk or field audit of the nursing facility's MA-11 cost report.

(3) The Department's denial, nonrenewal or termination of the nursing facility's MA provider agreement.

(4) The MA CMI established quarterly by the Department for the facility.

(5) The Department's imposition of sanctions or fines on the nursing facility under Subchapter I (relating to enforcement of compliance for nursing facilities with deficiencies).

(6) The total facility CMI established annually by the Department for the nursing facility.

(7) The rate established annually by the Department for the nursing facility for resident care cost, other resident related cost, administrative cost and capital cost.

(8) The quarterly adjustment made by the Department to the nursing facility's rate based upon the facility's MA CMI. The facility may appeal the quarterly rate adjustment only as to the issue of whether the quarterly rate adjustment was calculated correctly.

(9) The disproportionate share incentive payment made annually by the Department to the nursing facility. A nursing facility may appeal its disproportionate share incentive payment only as to the issue of whether the Department used the correct number of MA days of care and the correct inflation factor in calculating the facility's payment.

(10) A retrospective gross adjustment made pursuant to § 1187.108 (relating to gross adjustments of nursing facility payments), for the peer group in which the nursing facility is included. The nursing facility may appeal the gross adjustment only as to the issue of whether the adjustment was calculated in accordance with a final administrative action or court order.

(i) A nursing facility may not challenge the validity or accuracy of the underlying action or order which resulted in the retrospective gross adjustment.

(ii) If more than one nursing facility in a peer group appeals a retrospective gross adjustment, the Office of Hearings and Appeals may consolidate for hearing the appeals relating to each peer group.

(b) A nursing facility appeal is subject to §1101.84 (relating to provider right of appeal).

(c) A nursing facility's appeal shall be filed within the following time limits:

(1) A nursing facility's appeal of the peer group prices shall be filed within 30 days of the date on which the Department publishes the peer group price in the *Pennsylvania Bulletin*.

(2) A nursing facility's appeal of the decisions listed in subsection (a)(2)-(10) shall be filed within 30 days of the date of the Department's letter transmitting or notifying the facility of the decision.

(d) A nursing facility's appeal shall meet the following requirements:

(1) A nursing facility's appeal shall be in writing, shall identify the decision appealed and, in appeals involving decisions identified in subsection (a)(2)-(10), shall enclose a copy of the Department's letter transmitting or notifying the nursing facility of the decision.

(2) A nursing facility's appeal shall state in detail the reasons why the facility believes the decision is factually or legally erroneous and the specific issues that the facility will raise in its appeal, including issues relating to the validity of Department regulations. In addition, a nursing facility appeal of findings in a desk or field audit report shall identify the specific findings that the facility believes are erroneous and the reasons why the findings are erroneous. Reasons and issues not stated in a nursing facility's appeal shall be deemed waived and will not be considered in the appeal or any subsequent related appeal, action or proceeding involving the same decision. Desk or field audit findings not identified in a nursing facility appeal will be deemed final and will not be subject to challenge in the appeal or any subsequent related appeal, action or proceeding involving the same desk or field audit.

(3) A nursing facility may amend its appeal in order to meet the requirements of paragraph (2) of this section. A nursing facility shall file its amended appeal within 90 days of the date of the decision appealed. An amended appeal shall be permitted only if the nursing facility's appeal was filed in accordance with the time limits set forth in subsection (c). No subsequent amendment of an appeal will be permitted except under §1187.1(d) (relating to policy).

(e) An appeal or an amended appeal shall be mailed to the Executive Director, Office of Hearings and Appeals, Department of Public Welfare, Post Office Box 2675, Harrisburg, Pennsylvania 17105. The date of filing is the date of receipt of the appeal or amended appeal by the Office of Hearings and Appeals.

(f) The Department may reopen an audit or a prior year's audit if an appeal is filed.

EXCEPTIONAL PAYMENT AGREEMENTS

A. Target Group:

The target group consists of limited high-tech residents, such as ventilator dependent (requires a ventilator eight or more hours per day) and head and spinal cord injured individuals, placed in a nursing facility's head injury program designed to rehabilitate the resident so he/she can be placed in a less restrictive community environment.

B. Areas of State in which Services will be Provided:

Entire state.

C. Explanation of Services:

The Department will issue an exceptional payment agreement to the participating nursing facility to pay for additional services which include: ventilator rental equipment, supplies necessary because of ventilator dependency, respiratory hours, additional nursing hours and intensive head injury programs with extensive physical, speech and occupational therapies. An exceptional payment agreement will be issued for each specified individual on a case-by-base basis and the additional costs will be negotiated on a case-by-case basis.

D. Determination of Services:

A physician from the Department will assess the resident to determine his/her special medical needs. The physician will do periodic assessments to determine what the resident's current special medical needs are and how these needs can be met.

E. Payment for Services:

The nursing facility will bill its regular skilled acuity level rate for the resident. An exceptional payment agreement will be issued authorizing the nursing facility to bill for the additional cost of care. The facility will submit a separate invoice each month for items specified in the exceptional payment agreement. Documentation must be attached to the invoice verifying what special services/supplies were actually received by the resident for the month. The Department will review the documentation and authorize payment only for services/supplies received by the resident for the applicable month.

F. Auditing for Services:

During the audit, the Department will ensure that the provider adjusts its reported costs on the Cost Report to account for its exceptional reimbursement. Payment by the Department of the rates permitted by the exceptional payment agreement shall be payment in full for additional nursing facility services/supplies (above the customary MA covered services) required and received by the specified resident.